

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318  
1003  
11674-63-046017  
FILED DEC - 2 1963VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri.		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.		Length of stay in 1b 8 days		c. CITY OR TOWN St. Louis.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 8514 Mora Lane (47)	
3. NAME OF DECEASED (Type or print) First Middle Last CARL LEON SCHOENING.			4. DATE OF DEATH Month Day Year November 24 1963.		
5. SEX M	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1894	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipe fitter.		10b. KIND OF BUSINESS OR INDUSTRY Building Ind.		11. BIRTHPLACE (City and state or country) Altamont, Illinois.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Henry Schoening.		13b. MOTHER'S MAIDEN NAME Josephine Hodapp.	
14. NAME OF HUSBAND OR WIFE Cecilia (Vanderhagen)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Cecilia Schoening, 8514 Mora Lane (47)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 163X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION St. Louis.		20g. COUNTY Missouri.		20h. STATE	
21. I attended the deceased from Feb. 9, 1957 to Nov. 24, 1963 and last saw her alive on Nov. 24, 1963. Death occurred at 4:35 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) C. J. Smith, M.D.		22b. ADDRESS 3720 Washington Blvd.	
22c. DATE SIGNED 11-25-63		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-27-63	
23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) St. Louis.		23e. STATE Missouri.	
24. FUNERAL DIRECTOR Buchholz Mortuary, Inc.		25. DATE RECD. BY LOCAL REG. NOV 26 1963		26. REGISTRAR'S SIGNATURE Cecil Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Wilfred H. Bensch*

Licensed Embalmer No. 4551

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.